



Home and Community Based Services-Adult Mental Health (HCBS-AMH)
Provider Selection Form

Form Type (check one): [ ] Initial [ ] Transfer
Individual Name (last, first, mi):
CARE ID Number: CMBHS ID:
Address (street, city, state, zip):
Date of Birth:
Legally Authorized Representative Name, if applicable: (last, first, mi)

To be completed by the HCBS-AMH individual and/or the LAR:

I have received a list of Home and Community Based Services-Adult Mental Health (HCBS-AMH) Recovery Management Entities and Service Providers that serve my community.

I am aware that I have the freedom to choose the person who provides Recovery Management and my HCBS-AMH Service Provider.

I have selected \_\_\_\_\_ as my Recovery Management Entity and \_\_\_\_\_ as my HCBS-AMH Provider of services for the Home and Community Based Services-Adult Mental Health program.

I understand that once enrolled, I may transfer to another Recovery Manager or HCBS-AMH Provider if I so choose. If I wish to change my Recovery Manager or HCBS-AMH Provider, I will follow the procedures as outlined in the Participant Handbook.

Point of Contact at referring entity (State Hospital/LMHA/LBHA) for PA and RM to contact for coordination of HCBS-AMH services:

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_
Email: \_\_\_\_\_

Signature & Date – Individual

Signature & Date – LAR (If applicable)

For Internal Use Only
HCBS-AMH Representative Date